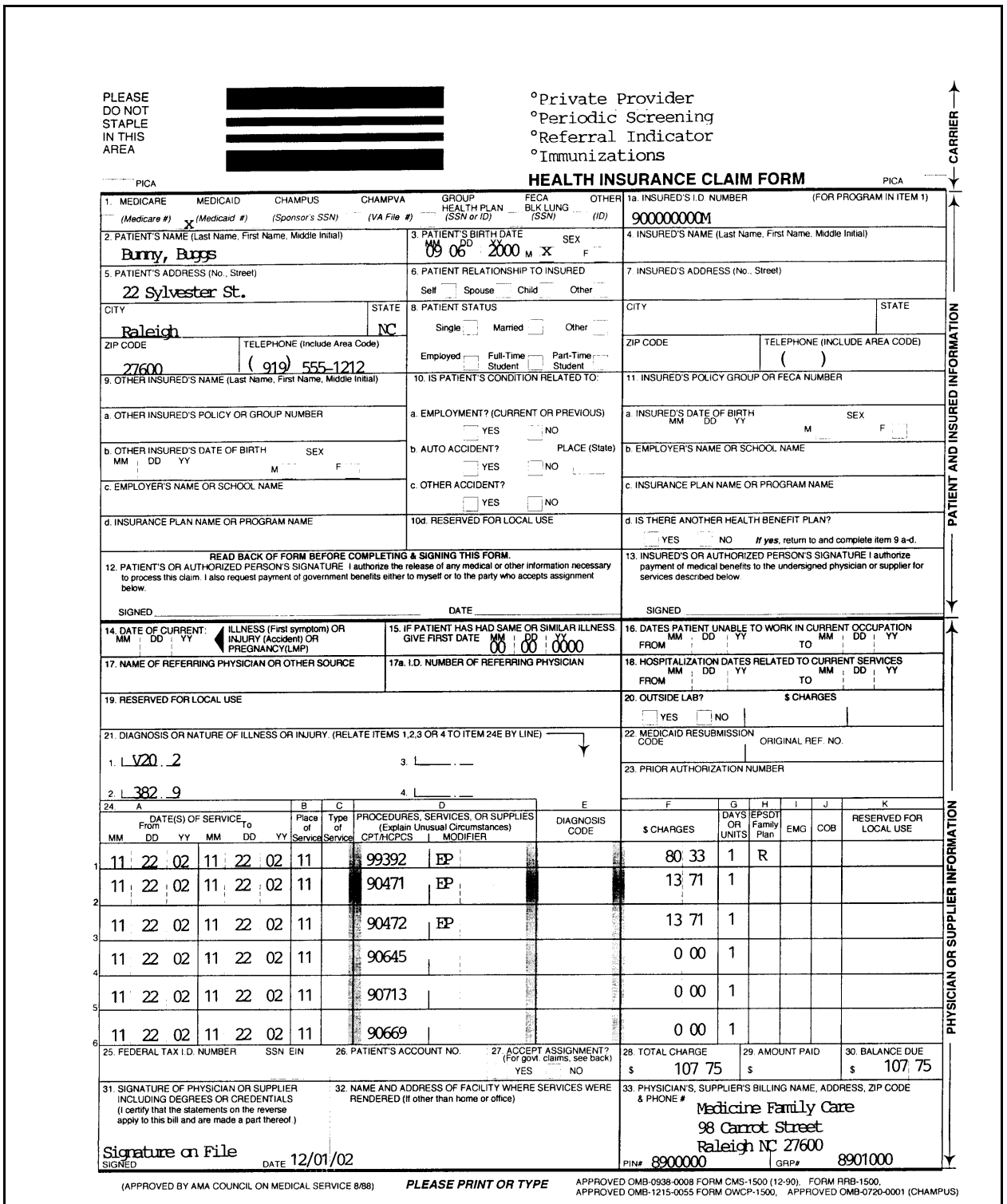

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Periodic Screening
°Referral Indicator
°Immunizations

**HEALTH INSURANCE CLAIM FORM**

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) — MEDICAID (Medicaid #) X — CHAMPUS (Sponsor's SSN) — CHAMPVA (VA File #) — GROUP HEALTH PLAN (SSN or ID) — FECA BLK LUNG (SSN) — OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000M

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Bunny, Buggs

3. PATIENT'S BIRTH DATE (MM DD YY): 09 06 2000 — SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 22 Sylvester St.

6. PATIENT RELATIONSHIP TO INSURED: Self — Spouse — Child — Other

7. INSURED'S ADDRESS (No., Street):

CITY: Raleigh — STATE: NC

8. PATIENT STATUS: Single — Married — Other; Employed — Full-Time Student — Part-Time Student

CITY — STATE

ZIP CODE: 27600 — TELEPHONE (Include Area Code): ( 919) 555-1212

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) — YES — NO

a. INSURED'S DATE OF BIRTH (MM DD YY) — SEX: M F

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) — SEX: M F

b. AUTO ACCIDENT? — YES — NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? — YES — NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? — YES — NO — *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: (MM DD YY) — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM DD YY): 00 00 0000

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM — TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? — YES — NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V20.2
2. 382.9
3. 
4. 

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 11 22 02 | 11 22 02 | 11 | | 99392 | EP | | 80 33 | 1 | R | | | |
| 2 11 22 02 | 11 22 02 | 11 | | 90471 | EP | | 13 71 | 1 | | | | |
| 3 11 22 02 | 11 22 02 | 11 | | 90472 | EP | | 13 71 | 1 | | | | |
| 4 11 22 02 | 11 22 02 | 11 | | 90645 | | | 0 00 | 1 | | | | |
| 5 11 22 02 | 11 22 02 | 11 | | 90713 | | | 0 00 | 1 | | | | |
| 6 11 22 02 | 11 22 02 | 11 | | 90669 | | | 0 00 | 1 | | | | |

25. FEDERAL TAX I.D. NUMBER — SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) — YES — NO

28. TOTAL CHARGE: $ 107 75

29. AMOUNT PAID: $

30. BALANCE DUE: $ 107 75

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED — DATE 12/01/02

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Medicine Family Care
98 Carrot Street
Raleigh NC 27600

PIN# 8900000 — GRP# 8901000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)